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No. 94-1818

Supreme Court, U.S.
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In the Supreme Court of the United States

OCTOBER TERM, 1995

EQUICOR, INC., PETITIONER

v.

LORDMANN ENTERPRISES, INC.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, preempts a state law tort claim brought by a health care provider against an ERISA benefits administrator for negligently misrepresenting to the provider that the provider would be paid in full for all services that it rendered to a plan participant.

TABLE OF CONTENTS

	Page
Statement	1
Argument	5
Conclusion	17

TABLE OF AUTHORITIES

Cases:

Abofreka v. *Alston Tobacco Co.*, 341 S.E.2d 622 (S.C. 1986)	12
Avco Corp. v. *Aero Lodge No. 735, Int'l Ass'n of Machinists*, 390 U.S. 557 (1968)	12
Baker Hospital v. *Aetna Life Ins. & Casualty Co.*, No. 91-2004, 1991 WL 179113 (4th Cir. July 29, 1991)	15
Baker Hospital v. *Isaac*, 391 S.E.2d 549 (S.C. 1990)	15
Caterpillar, Inc. v. *Williams*, 482 U.S. 386 (1987)	12-13
Cefalu v. *B.F. Goodrich Co.*, 871 F.2d 1290 (5th Cir. 1989)	13
Coleman v. *Nationwide Life Ins. Co.*, 969 F.2d 54 (4th Cir. 1992), cert. denied, 113 S. Ct. 1051 (1993)	13
Cromwell v. *Equicor-Equitable HCA Corp.*, 944 F.2d 1272 (6th Cir. 1991), cert. dismissed, 113 S. Ct. 2 (1992)	5, 15, 16
Curtiss-Wright Corp. v. *Schoonejongen*, 115 S. Ct. 1223 (1995)	14
District of Columbia v. *Greater Washington Board of Trade*, 113 S. Ct. 580 (1992)	6
Firestone Tire & Rubber Co. v. *Bruch*, 489 U.S. 101 (1989)	10
Fort Halifax Packing Co. v. *Coyne*, 482 U.S. 1 (1987)	9, 10
Hermann Hospital v. *MEBA Medical & Benefits Plan*, 845 F.2d 1286 (5th Cir. 1988)	9, 15
Hospice of Metro Denver, Inc. v. *Group Health Ins. of Oklahoma, Inc.*, 944 F.2d 752 (10th Cir. 1991)	5, 14
Ingersoll-Rand Co. v. *McClendon*, 498 U.S. 133 (1990)	6, 7

Cases—Continued: Page

Mackey v. *Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988) 6, 9, 12
Marks v. *United States*, 430 U.S. 188 (1977) 16
Memorial Hospital Sys. v. *Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990) 5, 8, 9, 10, 12, 14, 15
Misic v. *Building Service Employees Health & Welfare Trust*, 789 F.2d 1374 (9th Cir. 1986) 15
Moore v. *Metropolitan Life Ins. Co.*, 856 F.2d 488 (2d Cir. 1988) 13
Nachwalter v. *Christie*, 805 F.2d 956 (11th Cir. 1986) .. 14
New York State Conference of Blue Cross & Blue Shield Plans v. *Travelers Ins. Co.*, 115 S. Ct. 1671 (1995) 5, 6, 7, 8, 10, 13, 16, 17
Pilot Life Ins. Co. v. *Dedeaux*, 481 U.S. 41 (1987) 5-6
Rebaldo v. *Cuomo*, 749 F.2d 133 (2d Cir. 1984), cert. denied, 472 U.S. 1008 (1985) 9-10
Shaw v. *Delta Air Lines, Inc.*, 463 U.S. 85 (1983) 6
Straub v. *Western Union Telegraph Co.*, 851 F.2d 1262 (10th Cir. 1988) 13-14
The Meadows v. *Employers Health Ins.*, 47 F.3d 1006 (9th Cir. 1995) 14, 15

Statutes and regulations:

Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.* 3
§ 2(b), 29 U.S.C. 1001(b) 10
§ 104(b), 29 U.S.C. 1024(b) 14
§ 402(a)(1), 29 U.S.C. 1102(a)(1) 14
§ 514(a), 29 U.S.C. 1144(a) 3, 5
Labor Management Relations Act, 1947, § 301, 29 U.S.C. 185 13

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This brief is submitted in response to the Court's invitation to the Solicitor General to express the views of the United States.

STATEMENT

1. Paula Mitchell was a participant in an employee welfare benefit plan sponsored by her employer, Hi-Fi Buys, Inc. Pet. App. A2. Under the terms of the plan, Mitchell and her infant daughter, Victoria, were eligible for health care benefits provided by a group insurance policy issued by First Equicor Life Insurance Co. (First Equicor) and administered by petitioner Equicor, Inc. *Ibid*; *id.* at B2. The policy, which

went into effect on June 1, 1990, provided for only 30 days of home nursing care per calendar year, but stated that Hi-Fi and petitioner could agree to cover further rehabilitation services if an insured became disabled because of "severe personal injury," a category that expressly included high-risk newborn infants. *Id.* at A2-A3.

Victoria was born in February 1990 with severe birth defects that required her to be hospitalized for almost the first five months of her life. Pet. App. A3, B2. After she was released from the hospital, Victoria required 12 hours of home nursing care each day. *Ibid.* Mitchell hired a nurse employed by respondent Lordmann Enterprises, Inc., to provide that care, and assigned to Lordmann her rights to benefits under the plan. *Id.* at A3, B2-B3. The content of the communications that followed between respondent and petitioner is disputed.

Respondent claims that, in July 1990, before providing its services, Susan Marot, its chief executive officer, contacted petitioner and was informed by Geri Castagno (of petitioner's Medical Case Management Department) that the plan would pay 80% of the cost of the proposed nursing care. Pet. App. A3-A4, B3. In October, when Marot called to update petitioner on Victoria's condition, Castagno represented that she had authority to increase the benefits payable and that she would arrange to have 100% of the nursing charges paid. *Id.* at A4, B3. Approximately six weeks later, Castagno informed Marot that there was a problem with Victoria's coverage. Castagno stated, however, that there was no need to discontinue nursing services, and assured Marot that so long as respondent billed Blue Cross/Blue Shield (the insurer

at the time of Victoria's birth) first, respondent would be paid in full for its services. *Id.* at A5, B3-B4.

For its part, petitioner agrees that Marot asked Castagno about coverage for Victoria's nursing care, but claims that Castagno stated only that nursing services "would be covered under group policy number 72610, or not covered, subject to the terms and conditions of the contract of insurance." Pet. App. B4-B5, A6.

Respondent completed its care for Victoria in January 1991. Pet. App. A6. In December 1991, First Equicor paid petitioner $9,952, which was 80% of respondent's bill for 30 days of care in 1990 and four days of care provided in January 1991, less the amount owed by Blue Cross/Blue Shield for the same care. Respondent collected $3,425 from Blue Cross/Blue Shield, leaving a balance of $59,432. *Id.* at A6, B5.

2. Respondent sued petitioner in state court in Georgia, asserting state law claims for fraudulent and negligent misrepresentation. Pet. App. A6-A7, B5. Petitioner removed the case to federal court, asserting federal question and diversity jurisdiction. *Id.* at A7. Respondent then amended its complaint to add two federal claims, in its capacity as Mitchell's assignee: a claim for plan benefits under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*; and an ERISA claim based upon federal common law equitable estoppel. Pet. App. A7, B5-B6.

In response to petitioner's motion for summary judgment, the district court held that respondent's state law fraud and negligent misrepresentation claims were preempted by Section 514(a) of ERISA, 29 U.S.C. 1144(a). Pet. App. B6-B9. Although the court acknowledged (*id.* at B8) that the claims "d[id] not

directly implicate the employee benefit plan," it reasoned (*id.* at B9) that allowing Lordmann, which was an assignee of a plan beneficiary, to make state law claims against the plan would permit it "to do that which a beneficiary cannot do under state law," and thus frustrate the purposes of the ERISA preemption provision.

The court also held that respondent could not prevail on its ERISA-based claims. It rejected respondent's claim for benefits under the plan itself, because the unambiguous terms of the written plan provided only for 80% coverage for 30 days per calendar year. Pet. App. B14, B18. The court recognized that the plan permitted Hi-Fi and petitioner, by agreement, to provide additional coverage for rehabilitation, but found that respondent had failed to present any evidence of such an agreement. *Id.* at B16-B18. The court then rejected respondent's federal common law equitable estoppel claim, because, it concluded, the terms of the written plan were clear and respondent presented no evidence that petitioner had spoken with an intent to deceive. *Id.* at B18-B20.

3. The court of appeals affirmed the dismissal of respondent's two ERISA-based claims for the reasons stated by the district court, Pet. App. A18-A22, and it also affirmed the dismissal of respondent's state law fraud claim on the ground that respondent failed to allege specific facts that would support an inference of scienter, *id.* at A10-A11. But the court reversed the judgment entered against respondent on its claim for negligent misrepresentation, concluding that the claim might be viable under Georgia law, *id.* at A11-A12, and agreeing with the Fifth and Tenth Circuits that state law claims brought by health care providers against plan insurers "too tenuously affect the

ERISA plans to be preempted by the Act," *id.* at A13-A14 (citing *Hospice of Metro Denver, Inc.* v. *Group Health Ins. of Oklahoma, Inc.*, 944 F.2d 752 (10th Cir. 1991), and *Memorial Hospital Sys.* v. *Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990)). In the court's view, preemption in this situation would defeat, rather than promote, the statutory goal of protecting plan participants, since health care providers might hesitate to provide services, or might raise their fees, if they could not rely on representations by insurers or plan administrators regarding coverage. Pet. App. A15-A16. Moreover, the court found regulation of the relationship between plan fiduciaries and health care providers (who "were not parties to the ERISA 'bargain'" and were not afforded "federal causes of action under ERISA") to be beyond the scope of the Act. *Id.* at A16-A17.

ARGUMENT

The decision of the court of appeals is correct, and it is in accord with decisions of the Fifth, Ninth and Tenth Circuits. Although the Sixth Circuit reached a contrary result in *Cromwell* v. *Equicor-Equitable HCA Corp.*, 944 F.2d 1272 (1991), cert. dismissed, 113 S. Ct. 2 (1992), the Sixth Circuit's ruling in that case rested on a view of ERISA preemption that this Court since disapproved in *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 115 S. Ct. 1671 (1995). Because the Sixth Circuit may, accordingly, revisit the issue and reach a result consistent with that of the other courts of appeals, further review at this juncture would be premature.

1. ERISA supersedes all state laws insofar as they "relate to" an ERISA plan. 29 U.S.C. 1144(a). The Court held in *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S.

41. 47 (1987), that the phrase "relate to" should be accorded a "broad common-sense meaning," and explained in *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983), that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to uch a plan." Under that construction, a state law may "relate to" an employee benefit plan, and be preempted, even if the law is not specifically or directly designed to affect such a plan. *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 139 (1990).

This Court has made clear, however, that pre-emption is not unlimited, and that some state actions may affect employee benefit plans "in too tenuous, remote, or peripheral a manner" to warrant a finding that they "relate to" a plan. *Shaw*, 463 U.S. at 100 n.21. That is so, the Court has explained, with respect to "many laws of general applicability." *District of Columbia* v. *Greater Washington Board of Trade*, 113 S. Ct. 580, 583 n.1 (1992). Thus, the Court held in *Mackey* v. *Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988), that ERISA does not pre-empt garnishment of plan benefits under state law, and noted in that regard that "lawsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan—are relatively commonplace," *id.* at 833.

Most recently, in *Travelers*, this Court rejected "uncritical literalism" in gauging the "measure of pre-emption" under ERISA, recognizing that, "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course." 115 S. Ct. at 1677; see also *ibid.* ("For the same

reasons that infinite relations cannot be the measure of pre-emption, neither can infinite connections."). Accordingly, the Court found it necessary to "go beyond the unhelpful text and the frustrating difficulty of defining [the] key term [of the ERISA preemption provision], and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Ibid.* It explained that ERISA preempts state laws "that mandate[] employee benefit structures or their administration," or that provide "alternat[ive] enforcement mechanisms," *id.* at 1678, because such laws are inconsistent with ERISA's goal of providing a "nationally uniform administration of employee benefit plans," *id.* at 1677-1678. But, invoking the "presumption that Congress does not intend to supplant state law," *id.* at 1676, the Court found that the New York hospital surcharge law at issue in *Travelers* did not "relate to" ERISA plans, despite the law's admitted purpose to make Blue Cross/Blue Shield coverage more economically attractive by exempting from the surcharge patients covered by Blue Cross/Blue Shield policies. The "indirect economic influence" of the surcharge law, like other laws that indirectly affect, but do not dictate, ERISA plans' market choices, was not sufficient to trigger preemption. *Id.* at 1679-1680.

2. The court of appeals' holding in this case is consistent with this Court's teachings. The cause of action for negligent misrepresentation under Georgia law does not refer to, and is not dependent on, the existence of an ERISA plan. See *Ingersoll-Rand*, 498 U.S. at 139 (distinguishing the state wrongful discharge law held preempted in that case from "a generally applicable statute that makes no reference

to, or indeed functions irrespective of, the existence of an ERISA plan"). Respondent's action also has no direct economic or administrative impact on the ERISA plan sponsored by Paula Mitchell's employer. It is not an action against the plan itself, but against the plan administrator, and it is not based on the participant's plan coverage, but on an assurance made by the administrator to a third-party provider. Any "one-time recovery * * * would not affect the on-going administration or obligations" of the plan, or expand the rights of the participant or her beneficiary to receive benefits under the terms of the plan. *Memorial Hospital*, 904 F.2d at 247; see also *id.* at 246.[1] In fact, Mitchell (the plan participant) is individually and primarily liable to pay for the services rendered by respondent, with the only question being whether the risk of non-payment should remain with the provider or be shifted to the plan administrator that allegedly misrepresented coverage. See *ibid.* "Enforcing the allocation of risks between com-

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[1] If respondent prevails in this action, petitioner will have to pay a judgment that presumably will be measured by the cost of unpaid services that respondent provided. But the employer's ERISA plan itself will not be modified, and the judgment will not affect its benefit structure generally or require changes in its administration. Cf. *Travelers*, 115 S. Ct. at 1678 (ERISA preempts "state laws that mandate[] employee benefit structures or their administration"). It is possible that the cost incurred by petitioner in paying the judgment will ultimately be borne in whole or in part by the ERISA plan, either pursuant to its contract with petitioner as administrator or in the form of higher rates for administrative services in the future. That consequence, however, would be the type of indirect and purely economic impact on plans that *Travelers* held insufficient to trigger preemption.

mercial entities that conduct business in a state is a classically important state interest" (*ibid.*) that "ERISA pre-emption analysis 'must * * * respect.'" *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 19 (1987).

Further, unlike respondent's claim for benefits directly under the ERISA plan and respondent's assertion of equitable estoppel, which derive from respondent's status as Mitchell's assignee, respondent's allegation of negligent misrepresentation is based on its independent status as a third-party health care provider. Health care providers are not ERISA principals; and although, as here, they may have certain derivative rights under ERISA if they have received a valid assignment from a participant or beneficiary, they do not have independent standing to seek redress under ERISA. See, *e.g.*, *Hermann Hospital* v. *MEBA Medical & Benefits Plan*, 845 F.2d 1286, 1290 (5th Cir. 1988). As the court below recognized, "[w]hen employers and employees gave up state law causes of action because of ERISA, they received federal causes of action under ERISA in exchange[,] [but] ERISA does not provide a cause of action for aggrieved health care providers that treat ERISA participants." Pet. App. A17. Because regulation of the provider/administrator relationship falls outside the scope of the Act, misrepresentation claims raised by health care providers do not "raise[] any issue concerning the matters that Congress intended to be regulated exclusively by ERISA." *Memorial Hospital*, 904 F.2d at 247. Rather, they are representative of the "run-of-the-mill state-law claims" that are beyond the sweep of ERISA pre-emption. *Mackey*, 486 U.S. at 833; cf. *Rebaldo* v. *Cuomo*, 749 F.2d 133, 138 (2d Cir. 1984) (ERISA

preemption "does not require the creation of a fully insulated legal world that excludes those plans from regulation of any purely local transaction"), cert. denied, 472 U.S. 1008 (1985).

Finally, it is unclear "how insulating plan fiduciaries from the consequences of their commercial dealings with third-party providers would further any of ERISA's goals." *Memorial Hospital*, 904 F.2d at 247. Congress enacted ERISA "to promote the interests of employees and their beneficiaries in employee benefit plans." *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 113 (1989) (citation omitted); see also 29 U.S.C. 1001(b). To that end, Congress intended, through the Act, to give employers the advantages of a uniform set of regulations governing plan fiduciary responsibilities and procedures for processing claims and paying benefits. *Travelers*, 115 S. Ct. at 1677-1678; *Fort Halifax*, 482 U.S. at 9-11. As the court below determined, however, preempting respondent's state law claim for misrepresentation would directly undercut the interests of participants and beneficiaries, because "commercial realities" require that "providers be able to rely on the insurers' representations as to coverage." Pet. App. A15.[2] If health care providers have no recourse

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[2] See *Memorial Hospital*, 904 F.2d at 246:

> The scenario * * * is reenacted each day across the country. A patient in need of medical care requests admission to a hospital (or seeks treatment from a doctor). The costs of medical care are high and many providers have only limited budget allocations for indigent care and for losses from patient nonpayment. Naturally, the provider wants to know if payment reasonably can be expected. Thus, one of the first steps in accepting a

in circumstances in which they have been misled by erroneous assurances about the extent of coverage, they "must either deny care or raise fees to protect themselves against the risk of noncoverage," Pet. App. A16, thereby harming the interests of participants and of the plans themselves in ensuring that medical services are readily available to covered employees and their dependents.

3. Petitioner argues (Pet. 16, 22-23) that because a plan administrator acts within the scope of its official duties when it provides information regarding the existence and extent of coverage under a benefit plan, the propriety of its conduct should be determined by a uniform body of federal law under ERISA, regardless of whether the plaintiff is a plan participant or, as here, a third-party health care provider. That a function is performed by a person in its capacity as a plan administrator does not mean, however, that its actions are insulated from state law causes of action.

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patient for treatment is to determine a financial source for the cost of care to be provided.

If a provider believes that a patient may be covered under a health care plan, it is customary practice to communicate with the plan agents to verify eligibility and coverage. If the provider confirms that a patient has health insurance that covers a substantial part of the expected costs of the health care, it will normally agree to admit the patient without further ado. Memorial contends that when an insurance company or its agent, including one acting as an ERISA plan fiduciary, verifies coverage to a third-party provider, the insurer should recognize the commercial implications to the provider of its assurances. Under Memorial's theory, the insurance company is agreeing to pay expenses within the represented terms of the policy or to accept the consequences for a false representation of coverage that the provider reasonably relied upon.

Indeed, as this Court has recognized, an ERISA plan may itself sue and be sued under state tort law. *Mackey*, 486 U.S. at 833.[3] Moreover, contrary to petitioner's assertion (Pet. 16), the identity of the party plaintiff is relevant to the determination whether its claim against an ERISA principal is preempted. ERISA preempts state law claims by beneficiaries against plan fiduciaries because, by defining the fiduciaries' duties towards plan beneficiaries and providing a mechanism for enforcement of those duties, the Act establishes a comprehensive scheme for regulation of the fiduciary/beneficiary relationship. In contrast, "[t]he Act imposes no fiduciary responsibilities in favor of third-party health care providers," *Memorial Hospital*, 904 F.2d at 247, and affords such providers no statutory cause of action for redress of injuries inflicted by plan fiduciaries.

Petitioner contends (Pet. 19-22) that the absence of an ERISA remedy for misleading statements made by plan administrators to health care providers is not relevant to the preemption analysis. Neither *Cater-*

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[3] Significantly, *Mackey* cited *Abofreka* v. *Alston Tobacco Co.*, 341 S.E.2d 622 (S.C. 1986), as an example of a type of tort claim commonly brought against plans or their fiduciaries that is not preempted by ERISA. 486 U.S. at 833 n.8. *Abofreka* involved a state libel claim by a doctor against plan fiduciaries who, based on their belief that the doctor had submitted fraudulent claims for benefits, posted notices to their covered employees not to use the doctor's services. 341 S.E.2d at 624. As the Fifth Circuit noted in *Memorial Hospital*, if ERISA does not preempt the *Abofreka* claim, despite its undeniable connection to the administrative activities of plan fiduciaries in processing the doctor's claims for benefits, a state law claim by a health care provider against a plan administrator for negligent misrepresentation "creates no greater preemptive concerns." 904 F.2d at 248-249.

pillar, Inc. v. *Williams*, 482 U.S. 386 (1987), nor *Avco Corp.* v. *Aero Lodge No. 735, Int'l Ass'n of Machinists*, 390 U.S. 557 (1968), supports that broad argument. Although both cases held that a state law cause of action may be preempted by Section 301 of the Labor Management Relations Act, 29 U.S.C. 185, even where federal law does not provide a parallel remedy, *Caterpillar*, 482 U.S. at 391 n.4; *Avco*, 390 U.S. at 561, neither case held that the existence *vel non* of a federal remedy is irrelevant to an analysis of the scope of federal preemption. To the extent that the presence or absence of a remedy under ERISA bears on Congress's intent regarding the scope of the Act, it is obviously a factor relevant to an assessment of the Act's preemptive range. See *Travelers*, 115 S. Ct. at 1677-1678.

Finally, petitioner argues (Pet. 22) that a health care provider's interests can be adequately protected, without resort to state tort law, through an assignment of the beneficiary's rights under the plan. Limiting a provider to the remedies available to the plan beneficiary, however, fails to take into account relevant differences in their respective positions. As a general rule, a beneficiary is held to the written terms of a plan and cannot enforce alleged oral representations or modifications that conflict with those written terms.[4] That is so because the written

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[4] In general, oral or informal written communication has been deemed ineffective to amend the terms of a written plan. See *Coleman* v. *Nationwide Life Ins. Co.*, 969 F.2d 54, 58-59 (4th Cir. 1992), cert. denied, 113 S. Ct. 1051 (1993); *Cefalu* v. *B.F. Goodrich Co.*, 871 F.2d 1290, 1295-1297 (5th Cir. 1989); *Moore* v. *Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988); *Straub* v. *Western Union Telegraph Co.*, 851 F.2d 1262,

plan document requirement of Section 402(a)(1) of ERISA, 29 U.S.C. 1102(a)(1), and the Act's reporting and disclosure scheme more generally, are designed to "enabl[e] beneficiaries to learn their rights and obligations at any time," *Curtiss-Wright Corp.* v. *Schoonejongen*, 115 S. Ct. 1223, 1230 (1995). See 29 U.S.C. 1024(b) (1988 & Supp. V 1993) (requiring the plan administrator to furnish participants and beneficiaries with a copy of the summary plan description and to make plan documents available for inspection by participants and beneficiaries). In light of this statutory scheme, it is one thing to hold a beneficiary responsible for knowing the terms of the plan under which she claims coverage, and quite another to presume that a third-party provider, who deals with numerous unrelated plans without having ready access to the governing plan documents, stands on equal footing with the administrator of a plan regarding matters of eligibility and coverage under that plan.

4. The decision of the court of appeals in this case is consistent with decisions of the Fifth, Ninth and Tenth Circuits holding that similar claims by health care providers are not preempted by ERISA. See *Memorial Hospital*, 904 F.2d at 245-249; *Hospice of Metro Denver*, 944 F.2d at 755; *The Meadows* v. *Employers Health Ins.*, 47 F.3d 1006, 1008, 1011 (9th Cir. 1995).[5]

1265 (10th Cir. 1988); *Nachwalter* v. *Christie*, 805 F.2d 956, 960 (11th Cir. 1986).

[5] Notably, the Fifth and Ninth Circuits have distinguished state law suits by a provider "as an *independent* entity claiming *damages*" from state law suits by a provider "as an *assignee* of a beneficiary's rights to *benefits*," and have found the lat-

The Sixth Circuit's decision in *Cromwell* v. *Equicor-Equitable HCA Corp.*, *supra*, thus stands alone in holding that a health care provider's state law claim against a plan administrator for negligently misrepresenting the extent of coverage is preempted by ERISA.[6] In *Cromwell*, a health care provider brought suit in state court based on the administrator's false assurance of coverage and subsequent refusal to pay. The provider alleged promissory estoppel, negligence, and, as an assignee of insurance benefits, derivative claims for breach of contract and breach of good faith. 944 F.2d at 1276-1277. After the case was removed to federal court, the district court dismissed the provider's state law claims as preempted by ERISA, and it granted the administrator's motion for summary judgment on the breach of contract and breach of good faith claims, which the court treated as claims for benefits under the Act. *Id.* at 1275. The court of appeals affirmed. Stressing the broad sweep of ERISA preemption, the court reasoned

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ter preempted by ERISA. *The Meadows*, 47 F.3d at 1008 (distinguishing *Misic* v. *Building Service Employees Health & Welfare Trust*, 789 F.2d 1374 (9th Cir. 1986)); *Memorial Hospital*, 904 F.2d at 245 n.12, 249 n.20, 250 (distinguishing *Hermann Hopsital* v. *MEBA Medical & Benefits Plan*, *supra*).

[6] Although the Fourth Circuit stated, in *Baker Hospital* v. *Aetna Life Ins. & Casualty Co.*, No. 91-2004, 1991 WL 179113, at *1 (July 29, 1991) (per curiam), that ERISA precluded a provider's state law promissory estoppel claim, the opinion was unpublished (and therefore did not establish circuit precedent), and the provider in that case conceded that its claims were preempted by ERISA. Similarly, in *Baker Hospital* v. *Isaac*, 391 S.E.2d 549, 550-551 (S.C. 1990), the parties stipulated that the provider's state law tort claims were preempted by ERISA. Both of those decisions predated *Travelers*.

that the state law claims were "at the very heart of issues within the scope of ERISA's exclusive regulation and, if allowed, would affect the relationship between plan principals by extending coverage beyond the terms of the plan." *Id.* at 1275-1276.

The decision in *Cromwell*, however, was split three ways, with only Senior District Judge Feikens subscribing to the above reasoning. Judge Suhrheinrich, concurring only in the result, focused on "the effect state law has on the plan." 944 F.2d at 1279. In his view, a judgment in this type of case, while not based in contract, "will nonetheless have to be paid by the plan"; "will require actuarial adjustments, since such a judgment will not have been a factor in the plan's projections"; and will subject the plan "to the laws of the individual states concerning the types of damages recoverable in tort, including consequential and punitive damages." *Ibid.* Judge Suhrheinrich concluded that those effects trigger preemption, because they result in "fewer funds available to pay the claims of beneficiaries" and "increase administrative costs." *Ibid.*

Judge Jones, dissenting, faulted the "majority" for its "overzealous" and "unreflective approach to ERISA preemption," 944 F.2d at 1279, an approach that "perhaps inadvertently * * * has enabled plan administrators, either intentionally or not, to give misinformation of coverage and avoid any inquiry into the validity of a health care provider's claims against them," *id.* at 1286.

The rationale of Judge Suhrheinrich's concurrence, which apparently was pivotal to the outcome of the case, see *Marks* v. *United States*, 430 U.S. 188, 193 (1977), is directly called into question by this Court's

later decision in *Travelers*. The "negative effects" on plans of holding plan administrators liable for torts committed against outside parties, like the effects of the surcharges in *Travelers*, are indirect and wholly economic, and "do[] not bind plan administrators to any particular choice." *Travelers*, 115 S. Ct. at 1679. It was precisely the existence, and indeed prevalence, of "common state action[s]" having such economic impacts that led this Court to question, and ultimately reject, the notion that ERISA displaces "all state laws affecting costs and charges." *Ibid.* As a result of *Travelers*' subsequent clarification of the standards for ERISA preemption, the Sixth Circuit may well reconsider its splintered ruling in *Cromwell* concerning the viability of a health care provider's independent state law claims against a plan administrator. Accordingly, we do not believe that review of that issue by this Court is warranted at the present time.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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